# LIFE-DISABILITY TRANSMITTTAL FORM

**NOTICE: THIS FORM MUST BE COMPLETED AND ACCOMPANY EACH FILING.**

**OIC use Only**

**[ ] File ID** **[ ] Analyst**

| | Date | Initials |
|---|---|---|
| [ ] Approved | | |
| [ ] File & Use | | |
| [ ] Deemed | | |
| [ ] Withdrawn | | |
| [ ] Deactivated | | |

**1.** Company Name & Address

_____

_____

_____

**2.** Date _____

**3.** CIC # or NAIC # _____

| | **check one only** | **check one only** |
|---|---|---|
| **4.** Type of Filing: | [ ] Rate<br>[ ] Form | [ ] Approval<br>[ ] Informational |

**5.** Rate or Form No. _____ **6.** Replaces Form No. _____

**(list only one)**

**7.** Title of new rate or form _____

**(list only one)**

**8.** Proposed Effective Date _____

All other forms attached to and made part of this filing need to be submitted on a Form Filing Transmittal Supplement, INSASUPP(04/99)

**9. TRADE SECRETS AND PREVENTION OF UNFAIR COMPETITION**

**[ ] RCW 48.02.120(3) provides that actuarial formulas, statistics and assumptions shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition. Insurers desiring to withhold specific information from public inspection shall: (1) check the box, and (2) clearly separate and identify the materials that are desired to be non-public. Preface the separated non-public materials with written justification.**

## 10. CHECK THE APPLICABLE TYPE OF FILING

**LIFE INSURANCE**

[ ] Individual Life
[ ] Individual Annuity
[ ] Universal Life
[ ] Indeterminate Premium
[ ] Variable Annuity Separate Account
[ ] Variable Life Separate Account

**RATE**
[ ] Rates
[ ] Actuarial Memorandum

**GROUP INSURANCE**

[ ] Group Life
[ ] Group Annuity
[ ] Group Disability
[ ] Group Medicare Supplement
[ ] Group Long-Term Care

[ ] Out-of-State Group
[ ] Association
[ ] Trust

**INDVIDUAL DISABILITY INSURANCE**

[ ] Disability/Health
[ ] Individual Long-Term Care
[ ] LTC Partnership
[ ] Individual Medicare Supplement

**CREDIT INSURANCE**

[ ] Credit Life
[ ] Credit Disability
[ ] Credit Life & Disability

**MISCELLANEOUS**

[ ] Accelerated Benefit
[ ] Viatical Settlements
[ ] Certificate of Assumption
[ ] Company Name Change
[ ]
[ ]
[ ]
[ ]

**11.** CONTACT _____
TITLE _____

**12.** TELEPHONE ( ) _____
FAX NUMBER ( ) _____
E-MAIL ADDRESS _____

**13. ADDRESS TO WHICH THIS FILING SHOULD BE RETURNED IF DIFFERENT THAN TOP OF PAGE.**

_____ _____ _____ _____
STREET/P.O. BOX CITY STATE ZIP

These forms and instructions are available at our web site at www.insurance.wa.gov a pdf file can be downloaded onto your computer using acrobat adobe viewer or you can click on the Word link.

INSA (11/00)